Indiana Division of Disability, Aging and Rehabilitative Services

Bureau of Quality Improvement Services

Bureau of Developmental Disabilities Services

INCIDENT REPORT - *Confidential*

For Use in Reporting

Circumstances in 431 IAC 1.1-3-1 (b), 460 IAC 6-9-5

and/or BQIS / BDDS Policy and Procedures

REV. 04-2004

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of _____

To Submit to BQIS / BDDS CENTRAL Office: E-Mail to BDDSIncidentReports@fssa.state.in.us OR FAX to (317) 233-2320

SECTION I - CONSUMER INFORMATION (Subject # 1)

SSN: **NAME** LAST: FIRST:

ADDRESS **CITY** **ST** **ZIP**

DOB **COUNTY** **GENDER** ☐ M ☐ F

SERVICE TYPE: ☐ SGL ☐ HHA ☐ HAB./VOC. ☐ DD WAIVER ☐ AUTISM WAIVER ☐ NURSING HOME ☐ SCHOOL
☐ SL ☐ HHC ☐ LP-ICF/MR ☐ A&D WAIVER ☐ SUPP SERVICES WAIVER ☐ CASE MGMT. ☐ SDC

SECTION II - ASSOCIATED PERSON (Subject # 2)

This Section is NOT to be Used For Additional Consumers

SSN (Optional): **NAME** LAST: FIRST:

ADDRESS **CITY** **ST** **ZIP**

AGE **EMPLOYER** **GENDER** ☐ M ☐ F

RELATIONSHIP TO SUBJECT
☐ ACQUAINTANCE ☐ EMPLOYER ☐ STRANGER ☐ OTHER
☐ CLIENT, OTHER ☐ FAMILY-GUARDIAN ☐ STAFF, HAB/VOC
☐ CO-WORKER ☐ HOUSEMATE ☐ STAFF, RESIDENTIAL

SECTION III - REPORTING PERSON and REPORTING AGENCY

NAME LAST: FIRST: **POSITION:** **PHONE #:** EXTENSION:

DATE OF REPORT: **REPORTING AGENCY:** **E-MAIL OF REPORTING AGENCY:**

INDIVIDUAL SUPERVISING AT TIME OF INCIDENT: **RESPONSIBLE SUPERVISORY PROVIDER:**

SECTION IV - INCIDENT INFORMATION

INCIDENT DATE: **TIME:**

WHERE OCCURRED? ☐ COMMUNITY ☐ COMMUNITY JOB ☐ COMMUNITY HAB. ☐ FAC. HAB. ADL ☐ WORKSHOP ☐ HOME, OWN
☐ HOME, FAMILY ☐ SGL ☐ SDC ☐ HHA ☐ HHC ☐ NF ☐ HOSPITAL ☐ LP-ICF/MR ☐ OTHER (Explain) ☐ SCHOOL

INDICATE WHICH of the FOLLOWING AGENCIES and/or INDIVIDUALS HAVE BEEN INFORMED

APS/CPS? ☐ YES ☐ N/A	LEGAL GUARDIAN? ☐ YES ☐ N/A	NAME	DATE
RES. PROVIDER? ☐ YES ☐ N/A	BDDS SC? (REQUIRED) ☐ YES	NAME	DATE
HAB/VOC PROVIDER? ☐ YES ☐ N/A	CASE MANAGER? ☐ YES ☐ N/A	NAME	DATE
BQIS CENTRAL OFFICE (REQUIRED) ☐ YES	DATE	**POLICE?** ☐ YES ☐ N/A	DATE

THIS SECTION IS FOR BQIS / BDDS CENTRAL OFFICE USE ONLY

DATE RECEIVED BY BQIS - BDDS:

ALL ACTION COMPLETED ON:

INCIDENT ID#

7-DAY FOLLOW-UP REQUIRED? ☐ YES ☐ NO

If YES, Who Completes the Follow-Up:

Group Home / QMRP ☐ Case Manager ☐

BDDS Service Coordinator ☐

State Form 51677 (4-04) / BQIS 0001